New York State Safe Sharps Collection Program

New York State Department of Health
Corning Tower - Room 412
Albany, New York 12237

Application for Registration to Accept Home Generated Sharps for Safe Disposal

Instructions: Please Complete All Parts of This Form and Return by Mail to the Above Address

---

Provider Type:

- ☐ Pharmacy licensed under Article 137 of the Education Law.[1]
- ☐ Health care practitioner.
- ☐ Health care facility licensed under Article 28 of the Public Health Law.
- ☐ Community-based organization
- ☐ Other _____
- ☐ Housing facility
- ☐ Educational Institution
- ☐ Public Works Department
- ☐ Municipal Government

Provider Information (please print or type)

Provider Name: _____

Address: _____

City: _____ State: _____Zip: _____

Telephone No.: _____ Fax No.: _____

Telephone No. for Public Information: _____

[1] Pharmacies should refer to the New York State Department of Health Guidelines for Pharmacies Interested in Accepting Hypodermic Needles, Syringes and Other Sharps Used Outside of Health Care Settings for Safe Disposal, contained within the ESAP Information for Providers on the NYSDOH website.

Designated Contact Person Information (please print or type)

Each authorized provider shall designate one (1) contact person to have administrative responsibility for the sharps collection program. Below, supply the requested information for the designated contact person.

Name: _____ Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____ e-mail Address: _____ Fax No: _____
(if available)

Safe Sharps Collection – Responsibilities

Applicants must specify the following: 1) the proposed site(s) for sharps collection; 2) the firm, company or other entity responsible for transporting and disposing of collected sharps in a manner consistent with all applicable NYSDEC rules and regulations; 3) the firm, company or other responsible entity for maintaining the collection unit including monitoring the unit to assure timely emptying of the unit; cleaning the unit and assuring the unit is in good working order. All individuals involved in maintaining, cleaning or otherwise servicing a collection unit must be properly trained in OSHA blood-borne pathogen standards (OSHA Directives CPL 2-2.69, Enforcement Procedures for the Occupational Exposure to Blood Borne Pathogens, 11/27/2001); 4) the firm, company or other responsible entity for emergency response to spills or other incidents involving the collection unit; and, 5) methods of assuring public awareness of the program through outreach and education.

1. Sharps Collection Site(s) (please attach additional sheets if more than one collection site is being registered for):

   All applicants must designate the site or sites for collection of household sharps, the specific location of the unit within the facility (i.e., entrance, lobby, patient waiting area etc.) and the anticipated days and hours of operation. In addition, applicants must designate the type of sharps collection unit that will be used at the site. Examples of sharps collection units include freestanding "kiosks" and wall-mounted units. Please specify in the space below the address of the proposed collection site including the type of collection unit (use additional sheets if necessary):

   Address: _____

   _____

   City: _____ State: _____ Zip: _____

   Telephone No.: _____

   Proposed Location of Collection Unit (i.e., entrance way, lobby, etc.):
   _____

   Days and Hours of Operation:

☐	Monday	Hours: _____
☐	Tuesday	Hours: _____
☐	Wednesday	Hours: _____
☐	Thursday	Hours: _____
☐	Friday	Hours: _____
☐	Saturday	Hours: _____
☐	Sunday	Hours: _____

   Type of Collection Unit: Freestanding Unit: _____
   Wall-mounted Unit: _____
   Other: _____

2. Regulated Medical Waste Hauler:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____

3. Collection Unit Contact Person(s):

Specification of who will be responsible for monitoring the collection unit; emptying it and cleaning it and in addition, who or where to call in the event of an accidental spill or other emergency.

Overall Responsibility:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____

Emergency Contact Person or Firm:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No.: _____

4. Methods of assuring public outreach and education (Please check, specify where appropriate and indicate if information will be available in languages other than English):

Print Media:

- ☐ Newspaper: _____
- ☐ Magazine: _____
- ☐ Newsletter: _____
- ☐ Other: _____
- ☐ Radio: _____
- ☐ Television: _____
- ☐ Brochures/Palm Cards etc.: _____
- ☐ Other (i.e., Health Fairs, Websites, community meetings): _____

Program Evaluation

☐ Please check here if you would like to participate in the program evaluation by providing information on program utilization including volume or pounds of sharps collected. **Participation is voluntary**.

Attestation

All program applicants agree to comply with applicable NYS Department of Health regulations for managing regulated medical waste (10 NYCRR Parts 70 and 405.24) and with all packaging, labeling, transport and disposal activity requirements as required and authorized by the NYS Department of Environmental Conservation. The authorized provider submitting this application attests that, upon being registered, it will abide by the provisions contained in this registration form. The authorized provider submitting this application also attests that it is in good standing with regard to the applicable licensing authority(ies) and that no final action of any sort has been taken which would bring such good standing into question. The authorized provider submitting this application further acknowledges and agrees that its registration may be terminated by the Department of Health in the event that it fails to comply with any pertinent section of law, or in the event it is determined by the Department of Health or other applicable licensing authority that it was not in good standing at the time of application for registration or any time thereafter.

Individual authorized to sign the registration form on behalf of the applicant.

Signature_____

Print or type _____
name and title

NOTE: Submission of a completed form does not constitute registration until the Department of Health acknowledges its acceptance of the registration. Syringes may not be accepted for disposal until the Department of Health provides you with a separate written acknowledgement that it has accepted your request for registration and that your registration is effective.